

**MURKIN DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-036684**

**FILED VS OCT 28 1959**

160

Registration District No. \_\_\_\_\_ Primary Registration District No. 55N Registrar's No. 154

STATE FILE NUMBER

MEMORANDUM

1. PLACE OF DEATH a. COUNTY <u>Jefferson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Joachim Township</u>		Length of stay in 1b _____	c. CITY OR TOWN <u>ST. LOUIS</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MOUNTAIN VIEW HOME</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6150 Emma</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Eckhardt</u> Last _____	4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>1959</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-16-1887</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____	IF UNDER 24 HR Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Germany</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Conrad Correll</u>	13b. MOTHER'S MAIDEN NAME <u>Not known</u>	14. NAME OF HUSBAND OR WIFE <u>Jacob</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Milton Eckhardt - Emma</u>	Address <u>6150</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Few min only</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	<u>several years</u>
	DUE TO (c) <u>Generalized Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY _____	STATE _____
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21. I attended the deceased from 5-19-1959 to 10-22-1959 and last saw her alive on 10-19-1957.  
Death occurred at 9:30 A.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>R. H. D. ... M.D.</u>	(Degree or title)	22b. ADDRESS <u>Crystal City, Mo</u>	22c. DATE SIGNED <u>10-22-1959</u>
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23. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE <u>10-23-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla</u>	23d. LOCATION (City, town, or county) <u>St. Louis Co Mo</u>	(State)
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24. FUNERAL DIRECTOR <u>A. Krou</u>	ADDRESS <u>2707 9th Street</u>	25. DATE RECD. BY LOCAL REG. <u>10-22-59</u>	26. REGISTRAR'S SIGNATURE <u>John N. Stoll Deputy</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.